BEFORE THE KANSAS WORKERS COMPENSATION APPEALS BOARD

ANGEL DE LUNA	)	
Claimant	)	
V.	)	
	)	Docket No. 1,066,245
ARMOUR ECKRICH MEATS	)	
Respondent	)	
AND	)	
	)	
INDEMNITY INS. CO. OF NORTH AMERICA	)	
Insurance Carrier	)	

ORDER

Claimant requested review of the May 27, 2015, Award by Administrative Law Judge (ALJ) Rebecca Sanders. The Board heard oral argument on October 6, 2015.

APPEARANCES

Jeffrey K. Cooper, of Topeka, Kansas, appeared for the claimant. Dallas L. Rakestraw, of Wichita, Kansas, appeared for respondent and its insurance carrier (respondent).

RECORD AND STIPULATIONS

The Board has considered the record and adopted the stipulations listed in the Award.

ISSUES

The ALJ awarded claimant a 19 percent whole body functional impairment and denied claimant's request for future medical treatment, finding the evidence was not persuasive that claimant would need future medical treatment beyond follow-up visits or that claimant might possibly need a back fusion in the future.

Claimant appeals, arguing the more credible evidence proves claimant has three vertebral compression fractures and Dr. Murati's 27 percent whole person functional impairment rating for the back should be utilized in claimant's award. Claimant also argues that he has proved he is entitled to future medical treatment based on the opinion of Dr. Murati.

Respondent argues the greater weight of the credible evidence indicates claimant sustained a 10 percent permanent partial functional impairment to the body as a whole. In the alternative, should the Board find claimant's impairment is greater than 10 percent, the Award should be affirmed. Finally, respondent contends claimant has failed to sustain his burden of proving he is in need of future medical treatment, despite being at maximum medical improvement (MMI).

Issues on appeal are:

1. What is the nature and extent of claimant's impairment?

2. Is claimant entitled to future medical benefits?

FINDINGS OF FACT

Claimant has worked for respondent for five years in maintenance. On May 8, 2012, claimant fell three or four feet off a machine and landed on concrete, striking his low back and right elbow. Claimant underwent x-rays and MRIs of the lumbar spine and right elbow. Claimant was diagnosed with recent compression deformities at L2, L3 and L4. X-rays of the right elbow displayed no fractures. Claimant was told the fractures would improve with time and he was returned to work with restrictions. By June 21, 2012, claimant had improved somewhat, but still experienced discomfort in his low back and anterior and posterior thighs along with numbness and tingling in his calves and ankles bilaterally. Claimant was referred to physical therapy, which provided little benefit.

Claimant met with board certified orthopedic surgeon, John M. Ciccarelli, M.D., for an examination on March 28, 2013. Claimant provided a consistent history of the accident. Claimant reported pain in his lower lumbar spine, bilateral leg pain radiating in an L5 type distribution down the anterior shin, cramps and numbness when he walks. Claimant denied prior back or leg difficulties.

Dr. Ciccarelli diagnosed two work-related compression deformities of the lumbar spine at L2 and L3, which he also described as compression burst fracture injuries, and a disc herniation at L4-5, with current ongoing L5 radiculopathy bilaterally. Dr. Ciccarelli opined the work injury was the prevailing factor of the L2 and L3 compression deformities. He also determined the disc herniation at L4-5 was work-related. He felt claimant was a candidate for an epidural steroid trial targeted at L4-5.

Dr. Ciccarelli filed an addendum to his March report on May 9, 2013, by which time he had reviewed claimant's April 17, 2013, MRI, which revealed desiccation spanning L1-S1; minimal nonstenotic disc bulging at L1-2 and L2-3; previous endplate compression fractures at L2 and L3; Schmorl's nodes at L2 and L3 and a broad based right paracentral disc protrusion at L4-5 that contacted the bilateral L5 nerve roots and displaced the right

L5 posteriorly. He continued to recommend epidural injections at L4-5. Shortly thereafter, Dr. Ciccarelli became claimant's authorized treating physician.

Dr. Ciccarelli later testified the compression fractures he originally identified were actually Schmorl's nodes, because the type of trauma claimant experienced, at his age, would not likely produce a compression fracture.

Dr. Ciccarelli testified:

> Q. Is it your opinion that it would be difficult to sustain a three-level compression fracture or a two-level compression fracture based upon the mechanism of injury that was provided to you, is that what you're saying, Doctor?
>
> A. Yes. And the fracture -- I mean -- and the way the invagination occurs, it's biomechanically not very likely to cause that type of deformity just centrally.[1]

On June 13, 2013, claimant reported no long-term relief from the injections. Dr. Ciccarelli then determined claimant was a candidate for a lumbar decompression discectomy at L4-5, which was performed on July 8, 2013. At the July 23, 2013, follow-up examination, claimant stated he was doing very well. Claimant's leg pain was greatly improved. Claimant was allowed to return to light duty work six weeks post surgery. Although claimant returned to work he was not able to comfortably work within his light duty restrictions. As a result, claimant experienced increased back and bilateral lower extremity pain, with tingling in his lower extremities. Another MRI of the lumbar spine was ordered.

When claimant was seen on September 19, 2013, he reported definite improvement. The MRI displayed no indication of re-herniation or nerve compromise. Claimant was referred to physical therapy for reconditioning. On November 7, 2013, claimant reported the therapy had improved his low back pain and tightness significantly. He was released from Dr. Ciccarelli's care at MMI. Claimant was given no formal restrictions for the lumbar spine injuries.

On December 5, 2013, claimant returned to Dr. Ciccarelli complaining of low back pain, sore knees and bilateral leg tiredness, but denied radicular complaints. Claimant remained at MMI, was given a refill of Zanaflex and told to try Aleve. In a letter dated January 9, 2014, Dr. Ciccarelli rated claimant at 10 percent permanent partial impairment to the whole body, based on the 4th edition of the AMA *Guides*.

Dr. Ciccarelli explained the differences and similarities between Schmorl's nodes and compression fractures. He acknowledged they have very similar appearances as they both cause deformity to the endplates of the vertebral body, which he had described as a

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[1] Ciccarelli Depo. at 19.

square block, if undamaged. An MRI assists in the diagnosis of a Schmorl's node as the protrusion of the disk into the vertebra can be identified. With the fracture there is no protrusion into the vertebra by the disk.

On cross-examination, Dr. Ciccarelli acknowledged the MRI taken shortly after claimant's accident, was read by the radiologist as displaying edema and swelling with possible compression fractures at L2, L3 and L4. The last time Dr. Ciccarelli saw claimant he prescribed ice and heat packs and prescribed Zanaflex, a muscle relaxer, for claimant.

At the request of his attorney, claimant met with board certified physical medicine and rehabilitation specialist, Pedro A. Murati, M.D., on October 29, 2013, for an examination. Claimant presented with complaints of low back pain down both legs, worse with walking; numbness and tingling in both feet and knees; and pain in both knees, worse on the left. Although claimant hit his right elbow in his fall, he had no elbow complaints at this evaluation. Additionally, at regular hearing, claimant advised the court no claim was being pursued for his knees.

Dr. Murati examined claimant and diagnosed status post bilateral partial laminectomy, L4; additional level bilateral partial laminectomy, L5; bilateral recess decompression, L4-5; lumbar discectomy, L4-5; utilization of free fat graft; bilateral joint dysfunction; bilateral patellofemoral syndrome secondary to repetitive job; and status post compression fractures of L2, L3 and L4. He opined, within all reasonable medical probability, the prevailing factor in the development of claimant's conditions was the work-related injury on May 8, 2012, and multiple traumas at work with respondent.

Claimant met with Dr. Murati for another examination on February 24, 2014, for the purpose of determining functional impairment. Claimant had the same complaints of low back pain going down both legs, worse with walking, numbness and tingling in both feet and knees, occasionally and pain in both knees, worse on the left.

Despite changes found during claimant's physical examination, Dr. Murati's diagnoses did not change. He recommended yearly follow-up visits for the low back and knees in case any complications ensued, and assigned permanent restrictions. He opined claimant had a combined impairment of 29 percent to the whole person, of which 27 percent was for the back.

Claimant met with board certified neurological surgeon, Paul S. Stein, M.D., on July 7, 2014, for a court-ordered independent medical examination (IME). Claimant had complaints of back and lower extremity pain. The history of the accident provided Dr. Stein was consistent with the histories and testimony provided by claimant. Claimant reported terrible back pain that went into his hips and down into his lower extremities. He also had numbness and tingling in his lower extremities, primarily at night. Claimant reported that 60 percent of his pain was in his back and 40 percent in his lower extremities. Claimant denied any prior history of low back or lower extremity problems.

Dr. Stein opined claimant sustained very mild superior endplate compressions at L2, L3, and L4 from the fall at work. The primary and prevailing factor for the treatment related to the fractures was the work accident. Dr. Stein determined there is a causal relationship between claimant's surgery at L4-5 and the work incident.

Under the 4th edition of the AMA *Guides*, Dr. Stein assigned a 15 percent whole person impairment for the compression fractures. He assigned a 10 percent whole person impairment for loss of motion of the lumbar spine surgery. He then combined the two impairments for a 24 percent whole person functional impairment.

On August 8, 2014, Dr. Stein, upon reviewing claimant's May 8, 2012, x-rays, May 8, 2012, MRI and April 17, 2013, MRI, found claimant only had two and not three compression fractures and changed his functional impairment rating to 19 percent. Dr. Stein determined ultimately that claimant did not suffer a compression fracture at L4.

Gregory J. Welle, M.D., a board certified radiologist, was asked by claimant's attorney to review diagnostic studies done on claimant, which he did on December 14, 2014. Dr. Welle noted the May 8, 2012, radiographs of the lumbar spine demonstrated mild anterior wedging of L2 and L3, consistent with compression fractures. He also noted Schmorl's nodes involving the superior endplates at L2 and L3.

He reviewed the May 8, 2012, MRI and concluded it demonstrated mild degrees of anterior wedging at L2 and L3, Schmorl's nodes at the superior endplates of L2 and L3 and bone marrow edema in L2, L3 and L4. The bone marrow was limited to the vertebral bodies and was consistent with acute osseous injury, as seen with acute compression fractures. There was no significant loss of height at L4, which could be regarded as a bone contusion.

Dr. Welle reviewed the June 21, 2012, radiograph and found it again showed anterior wedging L2 and L3 consistent with compression fractures. There was mild superior endplate irregularity at L2 and L3. At his deposition, Dr. Welle testified that, in his opinion, everybody would describe L2 and L3 as compression fractures with associated bone marrow edema and loss of height.

Dr. Welle reviewed the September 25, 2012, radiograph and found it showed the L2 and L3 compression fractures were stable. He also found subtle focal concave deformities of the superior endplates consistent with Schmorl's nodes at L2 and L3. Dr. Welle was unwilling to call the deformity at L4 a Schmorl node. There were no significant changes from the last exam.

Dr. Welle reviewed the April 17, 2013, MRI and found it showed compression deformities at L2 and L3, which were mild anterior wedging and loss of height, with Schmorl's nodes at the superior endplates of L2 and L3. The bone marrow edema appeared to have resolved, indicating the fractures were healing or nearly completely

healed. He felt the fractures were less likely to be symptomatic, but could still be a source of back pain. There was bulging at L4-5, but it did not appear to cause significant nerve root impingement.

Finally, Dr. Welle reviewed the September 17, 2013, MRI and found the compression fractures were stable. The degree of wedging and loss of height remained unchanged. There were still small Schmorl's nodes at the superior endplates of L2 and L3. Contrasted images showed post-surgical changes at L4-5. The L4 lamina and spinous process appeared to be partially absent. There was enhancement in the epidural space circumferentially at L4-5, consistent with mild post surgical epidural fibrosis. L4-5 showed minimal residual bulging, but there was no stenosis or recurrent disc herniation or extrusion and no evidence of epidural abscess.

Claimant testified he continues to have pain in his low back that radiates into his legs and feet and into his toes. He has trouble walking and sitting and wakes up at night because of the pain. Claimant is still able to work, but he must do so slowly. He takes Advil and Tylenol at bedtime to help with the pain.

Claimant can no longer dance, play soccer, ride a horse or do anything domestic because of the pain. Claimant testified he does not do housework because he gets tired. The housework he referred to was periodic maintenance like painting and fixing things.

PRINCIPLES OF LAW AND ANALYSIS

K.S.A. 2011 Supp. 44-501b(b)(c) states:

> (b) If in any employment to which the workers compensation act applies, an employee suffers personal injury by accident, repetitive trauma or occupational disease arising out of and in the course of employment, the employer shall be liable to pay compensation to the employee in accordance with and subject to the provisions of the workers compensation act.
> (c) The burden of proof shall be on the claimant to establish the claimant's right to an award of compensation and to prove the various conditions on which the claimant's right depends. In determining whether the claimant has satisfied this burden of proof, the trier of fact shall consider the whole record.

K.S.A. 2011 Supp. 44-508(d) states:

> (d) "Accident" means an undesigned, sudden and unexpected traumatic event, usually of an afflictive or unfortunate nature and often, but not necessarily, accompanied by a manifestation of force. An accident shall be identifiable by time and place of occurrence, produce at the time symptoms of an injury, and occur during a single work shift. The accident must be the prevailing factor in causing the injury. "Accident" shall in no case be construed to include repetitive trauma in any form.

K.S.A. 2011 Supp. 44-508(g) states:

> (g) "Prevailing" as it relates to the term "factor" means the primary factor, in relation to any other factor. In determining what constitutes the "prevailing factor" in a given case, the administrative law judge shall consider all relevant evidence submitted by the parties.

K.S.A. 2011 Supp. 44-510e(a)(2)(A)(B) states:

> (2) (A) Permanent partial general disability exists when the employee is disabled in a manner which is partial in character and permanent in quality and which is not covered by the schedule in K.S.A. 44-510d, and amendments thereto. Compensation for permanent partial general disability shall also be paid as provided in this section where an injury results in:
> (i) The loss of or loss of use of a shoulder, arm, forearm or hand of one upper extremity, combined with the loss of or loss of use of a shoulder, arm, forearm or hand of the other upper extremity;
> (ii) the loss of or loss of use of a leg, lower leg or foot of one lower extremity, combined with the loss of or loss of use of a leg, lower leg or foot of the other lower extremity; or
> (iii) the loss of or loss of use of both eyes.
> (B) The extent of permanent partial general disability shall be the percentage of functional impairment the employee sustained on account of the injury as established by competent medical evidence and based on the fourth edition of the American medical association guides to the evaluation of permanent impairment, if the impairment is contained therein.

This record supports a finding that claimant suffered compression fractures at two levels, L2 and L3. Along with the resulting back surgery, claimant has suffered a 19 percent whole person functional impairment, based upon the opinion of Dr. Stein. The Award of the ALJ is affirmed on this issue.

K.S.A. 2011 Supp. 44-510h(e) states:

> (e) It is presumed that the employer's obligation to provide the services of a health care provider, and such medical, surgical and hospital treatment, including nursing, medicines, medical and surgical supplies, ambulance, crutches, apparatus and transportation to and from the home of the injured employee to a place outside the community in which such employee resides, and within such community if the director, in the director's discretion, so orders, including transportation expenses computed in accordance with subsection (a) of K.S.A. 44-515, and amendments thereto, shall terminate upon the employee reaching maximum medical improvement. Such presumption may be overcome with medical evidence that it is more probably true than not that additional medical treatment will be necessary after such time as the employee reaches maximum medical improvement. The term "medical treatment" as used in this subsection (e) means only that treatment

> provided or prescribed by a licensed health care provider and shall not include home exercise programs or over-the-counter medications.

The ALJ determined claimant was not in need of future medical treatment and, pursuant to the statute, denied the same. Only Dr. Murati expressed a need for future medical treatment for claimant. However, at his last visit with claimant, Dr. Ciccarelli noted claimant's ongoing pain complaints and prescribed heat and ice treatments, along with a prescription for Zanaflex, a muscle relaxer. This, along with claimant's ongoing complaints, convinces the Board that claimant will need future medical treatment. As such, claimant has overcome the presumption that respondent's obligation to provide medical treatment should terminate. The Award of the ALJ on this issue is reversed.

CONCLUSIONS

Having reviewed the entire evidentiary file contained herein, the Board finds the Award of the ALJ should be affirmed in part and reversed in part. Claimant is awarded a 19 percent whole person functional impairment for the injuries suffered on May 8, 2012, and is awarded future medical treatment upon application to and approval by the Director. In all other regards, the Award of the ALJ is affirmed insofar as it does not contradict the findings and conclusions contained herein.

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award of Administrative Law Judge Rebecca Sanders dated May 27, 2015, is affirmed in that claimant is awarded a 19 percent whole person functional impairment as above noted and reversed to grant future medical treatment upon application to and approval by the Director. In all other regards the Award of the ALJ is affirmed insofar as it does not contradict the findings and conclusions contained herein.

IT IS SO ORDERED.

Dated this _____ day of November, 2015.

_____
BOARD MEMBER

_____
BOARD MEMBER

_____
BOARD MEMBER

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